Prescription Pain Medication Program
Steering Committee Minutes
October 21, 2008
Rm 401

Agenda:

1. Update on Prescription Safety Week
2. Guidelines: Update of where we are and next steps
3. Review of 3 Tools for Guidelines
4. Review and discuss contract with Vanguard (will postpone discussion on provider education contract until November)

Action Items:

1. Bob will incorporate the two suggestions into guidelines (if major changes, will go through process with guideline panel; if minor, will make changes and send finalized draft out for comment)
2. Alan will work with Iona on the function part of the tool
3. Iona will send the revised tools to the Steering committee and guideline groups to get feedback before Oct 30
4. Kim will send Iona the name of person who helped with Bronchitis Guideline

1. Prescription Safety Week
Editorials in Deseret News and SL Tribune
Public Forum on Thursday
Traveling displays throughout high traffic areas
Governor's Proclamation that this is "Prescription Safety Awareness Week"

2. Guidelines
Getting close
Will be open for public comment for 30 days after finalized
One of the questions is whether to change the text from 120 mg to 200 mg (for the limit of morphine equivalents per day before a consultation with a pain management expert should be considered) based on the fact that there is no hard evidence to support this.

Kim—by giving parameters (even without evidence) we are reducing how much prescriptions will be prescribed (if we keep it at 120, people will think twice about prescribing beyond 120mg. if we recommend a sleep study, providers will be more likely to not prescribe high rates in order to avoid a sleep study).

Alan—really pushing to have a peer consult required if moving from acute to chronic use of opioids (from acute/limited to ongoing).

Kim—we say to do a risk assessment before starting a trial, but we don't follow up by saying "if they are high risk, do this and if they are low risk, do that".

Bob—there are two suggestions: in the beginning of the trial make it clear that there is a transition that will be from time-limited to chronic and at that time a peer consult will help to check on this (and Kim suggests that this should be done for a high-risk subset of individuals).

Kim—the guidelines don't address acute very much.

Bob—could be a checkpoint when someone is migrating from acute to chronic treatment.

Erin—one other question is whether to add "4) In general, use of long duration opioids are not appropriate for acute pain, including post-operative pain."

All—this seems to be generally accepted and should be added

Bob—as I go through the guidelines I will look at incorporating these things

3. Feedback on Tools
    1. Resources tool: rather than include the hard copies of these laws, we can include the URL's to direct people.

        Eliminate C-F (will be elsewhere in the guideline)
        List of pain management specialists: must either list everyone or have an objective way of listing.
        UDOH doesn't need to manage the list of pain management specialists: 211 and major health plans that can be used to identify a specialist and add phone number or URL that leads to Medicaid's pain management
        Eliminate urine drug screen sources
        Add the map to the mental health providers (ask Craig where to find the URL)

        Some statement: if there are legal or workplace concerns, we recommend going to the industrial clinic

    Alan—if the HealthInsight presentation highlights the usefulness of the URL's, docs are more likely to go to them

    Kim—when appropriate, I can add these in the ppt, but for the most part they may be periphery. (can do this for some, but not all)

    Iona—summarize what is in each of the URL's what they can find in it.

    The resources are back-up material.

Bob—if we can put more detail, that is fine, but as it is it is helpful. And the laws are very complicated—may not be our job to clarify the laws, but just to provide people with the resources.

Alan—would be good to have a course that goes through these and teaches docs the valuable info about the laws. The employees guide to worker's compensation has an easy FAQ. We could make a similar FAQ for docs.

Comprehensive Eval Tool:
Need to document the ORT (author and source)
Scale for pain should be 1-10
"initial dopl csdb screen" should be on one line—more clear
Add yes/no for obesity and hx of sleep apnea
Need to add footnote that leads them to the part of the guidelines where it talks about validation of the ORT and what to do for low risk, mod risk, high risk
Add Start Date, Review Date to the initiation of trial (so there is an expectation of the review)
Total Dose per Day
Typo: EKG
Change morphine equivalent to match what the guidelines say
Change methadone
Add line for consultation if over the mg's of morphine equivalent
Add "only" if receiving methadone (check spelling) do an EKG
Make the consultation/referral into If statements
Add baseline measure and goal columns with the 4A's.
Visual: last 4 boxes are crowded (the 4A's). They may belong better in the trial rather than in the top part—so that docs can see the goals and baseline.
Replace the 4 boxes with a box that says "sign a written treatment plan".
Create something between trial and maintenance where there is space for comments/results of trial/decision
Increase space on top and bottom—smaller borders
Name on left
Patient ID number

Pain and Medication Tracking Chart
No need to couple the two scales (from comprehensive eval tool and tracking chart)
Alan—I like these because we can standardize. We can improve the "function" part.
Bob—would like this to last several weeks
Kim—label it as Patient Log for Trial Period
Fewer lines needed for meds
No color or shades
Make a month fit on one page

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4. Vanguard Contract Renewal
Craig—TV is the best (although most expensive) way to educate community
Alan—my patients haven't seen the Use Only As Directed…it may not be reaching